

## STATE OF NEW JERSEY, ACCIDENT BLANK

Report every accident, no matter how small, and in case of fatal accident or serious injury, telephone or telegraph at once, giving date of inquest, if any. A compensable occupational disease is to be considered an accident.

This report of accident or occupational disease is to be prepared in TRIPLICATE. The original is to be sent to the Department of Labor, Bureau of Industrial Statistics, State House, Trenton, N. J. Carbon copy will not serve. Triplicate copy is to be kept on file by the employer. Duplicate copy is to be sent to

## THE EMPLOYERS' LIABILITY ASSURANCE CORPORATION, LTD.

1180 Raymond Boulevard - Raymond-Commerce Building

Newark, N. J.

FORM "C". First notice of Accident. For use by insuring employers.

<p>Newark Eagles Baseball Club (Name of Employer)</p> <p>71 Crawford St. (Street Address)</p> <p>Newark N. Jersey (City or Town)</p> <p>professional baseball (Business)</p> <p>Date report received Leave this line blank</p> <p>1. State fully how accident occurred..... Richardson was at bat, the ball thrown by the pitcher hit his finger</p> <p>2. Exact part of person injured, with nature and extent of injury first finger of the right hand. nail is coming off. no</p> <p>Was amputation necessary?.....</p> <p>12. Give probable period of disability.....</p> <p>13. Was medical attention necessary?..... yes</p> <p>14. Name and address of attending physician..... Dr. Walter Darden</p> <p>149 W. Kinney St. Newark N.J.</p> <p>15. If sent to hospital, state name and location.....</p> <p>16. Exact location of accident. If away from plant, give town, street and number..... Yankee Stadium Baseball Park New York City</p> <p>Date of preparing this blank..... July 16 1943</p>	<p>Date of Accident</p> <p>7 Number of Month</p> <p>11 Day of Month</p> <p>43 Year</p> <p>4 A. M. P. M.</p> <p>Hour male 3. (Occupation) 18yrs. 4. (Nationality) no</p> <p>5. Sex..... 6. Age..... 7. Married.....</p> <p>8. Give name of machine or appliance involved..... baseball</p> <p>9. Indicate kind of work done on this machine.....</p> <p>10. Name distinct part of machine causing injury.....</p> <p>11. Was any guard protecting this portion of the machine?.....</p> <p>17. Were the wages fixed by the output?.....</p> <p>18. If the wages were fixed by the hour, state RATE per hour.....</p> <p>19. Give number of HOURS in ordinary day.....</p> <p>20. Give number of DAYS in ordinary working week..... 42.50</p> <p>21. State the amount of weekly WAGES.....</p> <p>Made out by..... Effa Manley</p> <p>bus. mgr</p> <p>Newark Eagles Baseball club</p>
--	---

Before detaching, fill in on FORM "D" names, date of accident, and mail seven days after.  
If employee has resumed work at time of reporting, do not detach.



Newark Eagles Baseball Club

(Name of Employer)

71 Crawford St.

(Street Address)

Newark N. Jersey

(City or Town)

Date of Accident

7 Number  
of  
Month

Earl Richardson

11 Day of  
Month

10 Glenridge Ave.

43

Year

Montclair, N. J.

(City or Town)

30. Did employee lose any time? **yes**

31. Date disability began **July 11 1943**

32. Is employee able to resume work? **no**

33. If so, on what DATE?

34. State length of disability, **July 16 1943** weeks, days

Date of preparing this blank 19

35. Date seven days after accident. **July 18 43**  
Must be mailed on or before

36. Report received.  
Leave this blank

37. If not able to work, give  
probable date of recovery

38. Has any permanent injury resulted?  
If so, describe fully on back of form

Made out by **Effa Manley bus. mgr.**

If employee is still disabled at the time of preparing FORM "C", fill in names on this supplemental report, detach it and forward same, duly completed, on the SEVENTH DAY after the day of the accident, or on the day the injured returns, if he is able to work before the expiration of seven days. If employee loses no time, or has returned to work at time of reporting, fill out FORM "D", but do not detach.

This report of accident is to be prepared in TRIPLICATE. Mail the original (if detached) to the Department of Labor, Compensation Bureau, State Office Building, Trenton, N. J. (carbon copy will not serve). Triplicate copy is to be kept on file by the employer. Duplicate copy is to be sent to

THE EMPLOYERS' LIABILITY ASSURANCE CORPORATION, LTD.

1180 Raymond Boulevard - Raymond-Commerce Building

Newark, N. J.

FORM "D". SUPPLEMENTAL REPORT. For use of insuring employers. When in need of blanks, apply to your insurance carrier.